UCI

SF 4400-MED (4-2005)
Supersedes (9-2004) issue

Sandia National Laboratories

Medical Insurance Enrollment Form

A. Medical Plan Information:

Select the plan you wish to enroll in or the plan you are currently enrolled in: ☐ Top ☐ Intermediate ☐ Basic ☐ CIGNA

B. Enrollment Information:

I am a(n): *(Check one)* ☐ Employee or Student employee ☐ Retiree ☐ Surviving Spouse ☐ COBRA participant

This is a(n): *(Check one)* ☐ New Enrollment ☐ Addition ☐ Reinstatement

Type of enrollment: *(Check one)* ☐ New Hire ☐ Marriage ☐ Birth ☐ Adoption Placement[2] ☐ Domestic Partner/Dependent[1]

☐ Other, *Please Describe:* _____

Qualifying event date (e.g., hire date, marriage date, etc.) _____

[1]include Domestic Partnership Affidavit with this form
[2]include adoption papers with this form

C. Primary member Information:

Last Name _____ First Name _____ Middle Initial _____ Date of Birth _____ Social Security Number _____

Street Address _____ City, State (Please Abbreviate) _____ Zip Code _____

Home Phone _____ Work Phone _____

Union Affiliation *(Check One)*:
☐ None ☐ MTC ☐ OPEIU ☐ SPA

D. Dependent Information:

Please list below each family member you wish to cover. *Note:* If you are currently covered and are only adding a new family member(s), you only need to list the new addition(s) to your plan. If you have more than five dependents, please complete an additional enrollment form.

Last Name, First Name, M.I.	Relationship to Employee	SSN	Sex	Birth Date

E. Other Health Care Coverage:

Do you or your dependents have other group health care coverage? ☐ Yes ☐ No If **yes**, please provide the following information:

Name(s) of person/people covered: _____

Primary member ID number: _____ Employer name: _____

Insurance company name & address: _____

F. Employee's Signature:

I understand that if a covered individual is injured through the act or omission of another, United of Omaha Life Insurance Company and CIGNA health plan require reimbursement for the benefits. I agree that the information provided above is true and correct to the best of my knowledge.

Employee Signature _____ Date _____

Note: This form must be received by the Benefits Customer Service Center within 31 days of the mid-year election change event if your premiums are deducted on a pre-tax basis.

Fax this form to 505-844-7535 or mail to:
Sandia National Laboratories
Attn: Benefits Customer Service
PO Box 5800 MS 1022
Albuquerque, NM 87185-1022

For Benefits Use Only:

Date change entered: _____

PS: _____ Rx: _____

Benefits Employee Signature _____